

Make The Right Move

State of Georgia Flexible Benefits Program
2010



Dental

Vision

Disability

Specified
Illness



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Welcome

The State of Georgia Flexible Benefits Program

Are you planning or expecting the birth or adoption of a child? Getting married soon? Are you caring for an aging parent? Is it time to start thinking about supplementing your retirement? These are just some of life's changes that could affect the health care and financial needs of you and your family.

This 2010 You Decide! booklet gives you an opportunity to review and understand your benefits package. It summarizes benefits available to employees and their dependents eligible to participate in the Flexible Benefits Program, along with certain procedures to be followed to obtain these benefits.

There are some plan enhancements for the 2010 Plan Year, so review all information carefully. It is up to you to understand all the options available and make the choices that best suit your needs. Making the right decisions about your options can make a real difference toward building a rewarding future for you and your family.





General Eligibility and Enrollment Information

Enrollment and Eligibility

You are eligible to participate in the Flexible Benefits Program if:

- You are a full-time regular employee who works at least 30 hours a week and are expected to work for at least nine months. Employees who work in a sheltered workshop or work transition program, contingent employees, temporary employees, and student employees are not eligible.
- You are a public schoolteacher, working at least 17.5 hours, and employed in a professionally certified capacity, working half time or more and not considered a “temporary” or “emergency” employee.
- You are an employee of a local school system holding a non-certificated position. You must be eligible to participate in the Teacher’s Retirement System (TRS) or its local equivalent, and you must work a minimum of 20 hours a week (or 60% of the time necessary to carry out the duties of the position, if that’s more than 20 hours).
- You are an employee of a local school system working at least 15 hours (or 60% of the time necessary to carry out the duties of your position, if that’s more than 15 hours) and you are eligible to participate in the Public School Employees’ Retirement System (PSERS), as defined by Paragraph 20 of Section 47-4-2 of the Georgia Code.
- You are an employee of a county or regional library and work at least 17.5 hours per week.
- Others deemed eligible by Federal or Georgia law.

If you aren’t sure whether you’re eligible, contact your personnel/payroll office.

Dependents Eligible For Coverage

Eligible dependents include:

- Your legal spouse
- Your dependent child/ren who are under age 26, unmarried, not employed with an organization for which the dependent is entitled to group insurance, and not in full-time active military service
- Your dependent child/ren who are age 26 or over, unmarried, and who are incapable of self-sustaining employment by reason of mental incapacity or physical disability
- Dependent child/ren are defined as you or your spouses’ natural or legally adopted child/ren.

Benefit Salary

Your Benefit Salary includes your base salary and salary supplements that are regular, non-temporary, and not more than the amount on which retirement contributions are calculated - is reflected on your Option Statement/Electronic Enrollment and remains constant for the entire Plan year. It is calculated on your date of hire or the Benefit Calculation Date. Any adjustments to the Benefit Salary, with the exception of errors (as determined by the Plan Administrator) shall be reflected on the following Benefit Calculation Date, to be effective for the following Plan Year. Promotions, demotions, adjustments due to certifications are not deemed to be errors. Benefit Salary is the pay used to calculate your pay-based coverage - employee life, AD&D, and disability.

Benefit Options Administrative Fees

December 2009 premiums for January 1, 2010 coverage will include a monthly 55¢ administrative fee added to each option with the exception of Spending Accounts, which has a \$3.20 fee per participant per month.



General Eligibility and Enrollment Information

Continued

Pre-Tax Premiums Help You Stretch Your Dollars

The Flexible Benefits Program allows you to save on taxes while you pay for your benefits. Pre-tax premiums reduce your taxable pay...and your taxes. That's because premiums for most of your insurance options, health benefit options, and spending account contributions are taken out of your paycheck before federal and state income taxes and Social Security (FICA) taxes are withheld.

This means your taxable pay is lower...and so are your taxes. It also means you have more in your paycheck - or more to spend on benefits than you would if you paid the same premiums with after-tax dollars.

Important Information If You Are A New Employee

- **New Hire Electronic Enrollment**

You can select your benefits using the New Hire Electronic Enrollment system located on the Team Georgia Connection/Flex web site (www.team.georgia.gov/flex).

- **Dental**

There is a much shorter waiting period in the Regular and PPO options if you sign up immediately. Late enrollment penalties will apply to the Regular and PPO options if you do not enroll now, but elect to do so in the future. The DHMO Option does not have waiting periods or late enrollment penalties, but you must use a DHMO network provider.

- **Spending Accounts**

Your paycheck reductions for the spending accounts will start the 15th of your first full calendar month of

employment. Your total contributions to each account are prorated by the number of months you participate in these options up to the maximum monthly amount allowed for each account. Once you enroll, you may submit claims for services incurred on or after the first of the month after you have completed one full calendar month of employment.

- **Long-Term Care**

You have a one-time opportunity to sign up for long-term care insurance without providing medical underwriting.

- **Employee Life, Spouse Life and Child Life**

You have a one-time opportunity to choose some employee, spouse and child life insurance coverage without providing medical underwriting. Please see Employee, Spouse, and Child Life section for specific limits.

- **Employee Specified Illness and Spousal Specified Illness**

You have a one-time opportunity to sign up for the Specified Illness guaranteed levels up to \$20,000 without providing medical underwriting. Coverage for children is included with the Employee benefit.

You have a one-time opportunity to sign up for the Spousal Specified Illness guaranteed level up to \$10,000 without providing medical underwriting

- **Disability**

There is a one-time opportunity to sign up for long-term disability coverage without providing medical underwriting during your new hire eligibility period. If you do not sign up now, you will need



General Eligibility and Enrollment Information

Continued

to complete an Evidence of Insurability Form.

There is a one-time opportunity to sign up for short-term disability without being subject to a late entrant waiting period during the new hire eligibility period. If you did not sign up then, you will be subject to the Late Enrollment Penalty.

- **Other Coverage**

There are no medical underwriting requirements at any time for legal insurance, AD&D, spending accounts, or vision benefits.

Be sure to consider your options carefully when you first enroll. If you decline or drop some of your State coverages and want to pick them up again another year, you may have to prove insurability through medical underwriting to be covered again, or have longer waiting periods to receive full benefits.

After You Enroll For Coverage

When Coverage Begins

Coverage for new options selected during the Plan Year 2010 Annual Enrollment will begin on January 1, 2010 as long as you have met all contractual and administrative requirements.

Your new premiums for your health benefit plan and spending account reductions begin December 15; other premiums begin December 31 (for semi-monthly pay periods). These dates may not apply if your department has a different pay schedule. Please check with your personnel/payroll office for more information. See specific plan descriptions for information about when your coverage begins.

If you are a new employee, benefit selection (electronic or paper) and all other necessary forms must be completed no later than 30 days after your hire date. Your coverage will begin on the first day of the month after you have completed a full calendar month of continuous employment.

Confirming Your Choices

You are responsible for the benefit selections entered on the Electronic Enrollment site. It is very important that you confirm your selections prior to the end of the enrollment period and ensure that you have a system generated confirmation number. You should print this Confirmation Statement page with the confirmation number to compare with the paper Confirmation Statement you will receive after the enrollment period has ended. The selections should be the same on both Statements. If they do not match, be sure that you are comparing the latest electronic Confirmation Statement. The choices confirmed at the end of the enrollment period are the valid choices. The Confirmation Statement does not guarantee your coverage in some benefit coverages that require additional information. If you have not completed and submitted the additional forms/information required by your selected plan, the choices shown on your Confirmation Statement may not be valid.

Compare your paycheck statements with your Confirmation Statement. It is your responsibility to notify your personnel/payroll office immediately if there is an error. Deductions should match the confirmed choices. Any changes to your benefit selections must be in accordance with IRS §125 and Employee Benefit Plan Council rules and regulations and approved by plan administrators.



General Eligibility and Enrollment Information

Continued

If you do not receive a paper Confirmation Statement prior to your first payroll deduction, please contact your personnel/payroll statement immediately.

To Change Your Decisions at Annual Enrollment

Every Annual Enrollment you can change your benefit decisions, based on which benefits are available and right for you. Remember, this is an annual agreement to allow the State to purchase some benefits for you through pre-tax premiums. You will not be able to change these benefit decisions until the next Annual Enrollment unless you have a qualifying change in status as described in the Terms and Conditions.

To Change Your Decisions Outside Annual Enrollment

Qualifying Change in Status Event

In general, the Internal Revenue Service prohibits you from changing any coverage elections, or enrolling in or canceling any coverage under the Flexible Benefits Program outside of Annual Enrollment. However, the rules of the Internal Revenue Service and the Employee Benefit Plan Council do permit you to change coverage or enroll or cancel coverage in certain limited circumstances, if the change corresponds to a qualifying change in status event.

The Employee Benefit Plan Council has the responsibility to interpret these rules and make the final decision as to whether you may enroll or change any coverage outside of the Annual Enrollment period. Your request for enrollment or a change outside of the enrollment period will only be considered

if you submit the proper documentation within the time frame allotted.

Your request for enrollment or a change in any other coverage under the Flexible Benefits Program must be submitted on the Change in Status Event Form and given to your employer's Benefits Coordinator within 30 days after a qualifying event. There will be no refund of premiums paid into the Plan, when a timely change is not made.

Submission of a request for enrollment or a change, or the occurrence of a qualifying event, does not guarantee that you will be able to change coverage outside the enrollment period. Please see your Benefits Coordinator if you have questions about when you may enroll or make changes outside the enrollment period. For a list of possible change in status events that might permit you to change one or more coverages under the Flexible Benefits Program, please refer to the Terms and Conditions in the back of this booklet. The changes outlined include dependent eligibility to participate in the Plan. When a dependent or a spouse ceases to be eligible to participate in the Plan, it is the responsibility of the employee to notify the Plan or the vendor.

Generally, any changes will go into effect the first of the month following the date when the payroll deduction is changed to reflect your new choice. For some benefits, however, when you change coverage based on the acquisition of dependents, the coverage effective date for the new coverage may be retroactive to the date of the acquisition of the dependent in some circumstances, or may be the first of the month following the request to change coverage. Please see your Benefits

General Eligibility and Enrollment Information

Continued

Coordinator for the rules that apply to any specific coverage program.

Continuation of Benefits During Leave or End of Employment

When you go on leave without pay, contact your personnel/payroll office and the Flexible Benefits Program. If you do not continue paying premiums for coverage, your benefits will be cancelled and you may be subject to penalties and wait periods, if allowed to re-enroll. You may be required to wait until the next Annual Enrollment period to re-enroll. Be sure to review each Plan Description for each option and see your personnel/payroll office for more information.

It is the responsibility of each employee to contact the vendor directly within the required timeframe, to continue coverage unless you are retiring and wish to continue your dental insurance via your retirement annuity or continue your vision and/or Health Care Spending Account via COBRA. In these situations, you should contact the Flexible Benefits Program.

If you leave active State employment and then return during the same plan year, your previous choices will remain in effect unless you report a qualifying change in status event.



Dental Plans

We offer a wide variety of dental plan choices. Each plan has different payment schedules and providers. Closely review these plans to determine which one best fits the needs of you and your family. Use the comparison chart in this guide to learn about the plans. Due to availability, your best option may depend on where you live or work, and you should check the availability of dentists carefully. The three dental plans are listed below according to the dentist network availability in geographic areas:

- Regular - For all employees throughout Georgia;
- Preferred Provider Organization (PPO)- Specifically for employees who live or work in metropolitan areas;
- Dental Health Maintenance Organization (DHMO, formerly Prepaid) - Specifically for employees who live or work in metropolitan areas.

Your Choices

Regular Option with United Concordia

- Benefits are determined using the 90th percentile rates for procedures.
- You may use any dentist you choose.
- You may choose a dentist in the available PPO network with benefits based on the maximum allowable charge (MAC). This may result in lower out of pocket costs.
- A non-network dentist is entitled to collect from you the difference between the amount of benefits payable by United Concordia and the dentist charge for that service.

PPO Option with United Concordia

- Benefits are based on the MAC determined by United Concordia and accepted by the PPO dentist.
- Enrollment in the PPO is with the PPO Program, not with a particular dentist. PPO dentists can discontinue their arrangement with the Program at any time.
- If you require the services of a specialist, ask your dentist to refer you to a PPO specialist.
- If you use the services of a non-PPO dentist:

The dentist is entitled to charge you the difference between the amount of benefits payable by United Concordia and the dentist's charge. This means you could pay more out-of-pocket expense for using a non-PPO dentist, because the payment will reflect the lower PPO scheduled fee.

Important Information for Regular and PPO Options

➤ **Six (6) Month Wait Period**

All New Hires and newly eligible dependents are subject to the Six (6) Month Wait Period for Type III and Orthodontia (dependents under age 19 only) services.

➤ **Late Entrant Limitations**

Late entrant limitations results in delayed benefits in the Regular and PPO plans for up to twenty four (24) months. This means you won't receive some benefits until you have participated in the dental plan for a specified period of time. If you are under the Late Entrant Penalty, you will not be able to receive Type II or Type III services for twelve (12) months and Type III services for twenty four (24) months.

Late Entrant Limitations will apply to:

- current employees who are enrolling in either the Regular or PPO Options for the first time and are not able to present a certificate of continuous coverage with a group dental plan; or
- employees who fail to pay premiums when they are on an unpaid leave, except for FMLA and Military Leave; or
- current employees who choose not to continue coverage and re-enroll at a later date.

❖ Important Note: New employees are not subject to the late entrant limitations as long as they enroll when first eligible.

DHMO Option with Cigna Dental

If you plan to select or are continuing the DHMO Option, please read the Patient Charge Schedule carefully, which is located on the TGC/Flex website (www.team.georgia.gov/flex).

- The DHMO option is an easy to use plan offering choice, quality, and savings with a focus on preventive care. Choose a general dentist from the CIGNA Dental network. Covered family members can each choose their own dentists, near home, work, or school.
- You will receive a Patient Charge Schedule listing all covered services and the corresponding patient charge for each service. For many services, there is no charge and other plan features include: no deductibles, no annual dollar maximums, no claim forms to file and no waiting periods for coverage.
- To find a participating CIGNA Dental Care network dentist call 1-800-642-5810 or log onto www.cigna.com.



Dental Options Comparison Chart

	REGULAR - United Concordia	PPO - United Concordia	DHMO - Cigna
TYPE I – PREVENTIVE	100% of the 90th percentile***	100% MAC**	100% Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
TYPE II – BASIC	80% of the 90th percentile***	90% MAC**	100% Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges (amalgam (silver) fillings only)
TYPE III – MAJOR	50% of the 90th percentile***	50% MAC**	60%* Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
ORTHODONTIA	50% of the 90th percentile***	50% MAC** for dependents	50% for employee for dependents under 19 under 19 (and eligible dependents*) Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
ANNUAL DEDUCTIBLE	\$50 per person; \$150 for family (applies to Type II and Type III Major services only) each plan year		NONE
MAXIMUM BENEFITS	\$1,000 per person each plan year; \$1,500 lifetime benefit for Orthodontia		NO MAXIMUM
WAITING PERIOD FOR BENEFITS	New employees or newly enrolled dependents – after six months of continuous coverage for Type III Major services and Orthodontia		NO WAITING PERIOD
LATE ENTRANT LIMITATIONS FOR	Current employees enrolling for coverage for the first time after 12 months continuous coverage for Type II Basic services; after 24 months		NO LIMITATION

*Your share of the cost for these services will actually be a flat dollar co-payment. See Schedule of Benefits for details.

TYPE I – PREVENTIVE	TYPE II – BASIC	TYPE III MAJOR	ORTHODONTIA
<ul style="list-style-type: none"> • Oral exams • Prophylaxis • Space maintainers for dependents under 14 • X-rays 	<ul style="list-style-type: none"> • Fillings • Root canals • Extractions • Scaling and root planing • Repairs to dentures, bridges, and crowns • Sealants, children under 16 	<ul style="list-style-type: none"> • Crowns • Dentures • Bridgework • Surgical periodontal 	<ul style="list-style-type: none"> • Cephalometric x-rays • Treatment study • Bands, appliances

**United Concordia reimburses all fee-for-service and PPO dentists according to the maximum allowable charge (MAC) schedules. The MAC is determined using charge

data submitted to United Concordia from more than 100,000 participating providers.

United Concordia policies & procedures and exclusions limitations apply.

This chart is a representative listing of services covered under the program.

***You may use a PPO provider even if you enrolled in the Regular Dental Option.

This may result in lower out-of-pocket costs.

Pre-Determination of Benefits

Under the Regular and PPO Dental Options, for any service of more than \$300, the service should be reviewed by United Concordia before receiving treatment.

Vision Plans with OptumHealth

Vision coverage is available with two plan options – Select and Select Plus. Both plans offer these features:

- covered exams and materials;
- statewide access to a network of panel providers;
- no claims to file for “in-network” benefits; and
- benefits for “out-of-network” providers.

The OptumHealth Vision Care participating provider network includes private practice optometrists, ophthalmologists and retail chains.

Your Options

Select Option

- The Select Plan covers standard single vision and standard lined multi focal lenses for glasses. Cosmetic lens options such as tinting, UV coating, progressive lenses, etc., are not covered, but are provided to OptumHealth Vision’s members at a savings below normal retail charges.
- Certain standard contact lenses, including daily wear, and up to 4 boxes of standard single vision disposable contacts are covered in full for your co-payments. Under the Select Plan, if you purchase contacts that are not among OptumHealth Vision’s “covered in full” selection, you will receive an annual \$105 allowance toward the purchase of contact lenses, and professional fees (i.e., fit and follow-up).

- To receive the full \$105 allowance under the Select Plan, you must receive your exam, fitting and evaluation at a single visit to the same network provider. The allowance will only apply to one purchase per plan year. You must submit all receipts at the same time. Any balance remaining and not used during the plan year when the purchase occurred will be forfeited.

Select Plus Option

- In addition to the coverage in the Select Plan, the Select Plus Plan does offer cosmetic lens options for Tints, UV, Polycarbonate and Basic Progressive lenses.
- To receive the full \$125 allowance under the Select plus Plan, you must receive your exam, fitting and evaluation at a single visit to the same network provider. The allowance will only apply to one purchase per plan year. You must submit all receipts at the same time. Any balance remaining and not used during the plan year when the purchase occurred will be forfeited.

Important Information for Select and Select Plus Plans

- Benefits are provided every 12 months for exams, lenses and/or contacts and every 24 months for frames measured from the last date of service. Note: Benefit service limitations are calculated on a rolling calendar year. Example: if you receive exam services in March, you will be eligible to receive another exam in March of the following year.

Select Plan Option

Service	In-Network Benefits	Out-of-Network Benefits
Routine Eye Exam <i>Every 12 months</i>	100% after \$10 copay	Reimburses up to \$40
Lenses Standard <i>Every 12 months</i>	100% after \$20 copay	
Single vision, or		Reimburses up to \$40
Lined Bifocal, or		Reimburses up to \$60
Lined Trifocal, or		Reimburses up to \$80
Lenticular		Reimburses up to \$80
Frames <i>Every 24 months after a \$20 materials copay*</i>	Retail locations (Wal-Mart) <ul style="list-style-type: none"> • Up to \$130 retail allowance toward any frame package • Frames below \$130 provided at no additional cost Private Doctors Office <ul style="list-style-type: none"> • \$50 wholesale allowance towards any frame. You pay the difference. • Group of select frames at no additional cost 	Reimburses up to \$45 of retail
Contact Lenses <i>Every 12 months in place of eyeglasses</i>		
Medically Necessary	Covered after \$20 materials copay	Reimburses up to \$210
Not Medically Necessary	Covered after \$20 material copay for covered lenses selected from OptumHealth's list. Up to four boxes of covered disposable contact lenses are included when using a network provider. All other contacts available through a \$105 allowance that includes fitting, follow-up & materials. Please note to receive the full \$105 credit, you must receive your exam, fitting evaluation and all contact materials at the same provider at the same time. (At Wal-Mart \$70 of the \$105 allowance is allocated to materials and \$35 to professional fees).	Up to \$105 max that includes fit, follow-up & materials
Refractive Eye Surgery Access to discounted provider locations throughout the United States. To find a participating laser eye surgeon, visit our web site at www.myoptumhealthvision.com	Discount only: The in-network benefit is a discount off the full retail price.	No benefits

Remember if you use in-network providers, you are responsible only for your portion of the cost. If you decide to use a non-network provider, you pay everything and file a claim to receive payment according to the out of network payment schedule.

* Must qualify as medically necessary as described in the enrollment booklet.

Select Plus Plan Option

Service	In-Network Benefits	Out-of-Network Benefits
Routine Eye Exam <i>Every 12 months</i>	100% after \$10 copay	Reimburses up to \$40
Lenses Standard <i>Every 12 months</i>	Lens Options covered are: Tints, UV, Polycarbonate and Basic Progressives lenses.	OON Lens options are not covered.
Single vision, or	100% after \$25 copay	Reimburses up to \$40
Lined Bifocal, or	100% after \$25 copay	Reimburses up to \$60
Lined Trifocal, or	100% after \$25 copay	Reimburses up to \$80
Lenticular	100% after \$25 copay	Reimburses up to \$80
Frames <i>Every 24 months after a \$20 materials copay*</i>	Retail locations (Wal-Mart) <ul style="list-style-type: none"> • Up to \$130 retail allowance toward any frame package • Frames below \$130 provided at no additional cost Private Doctors Office <ul style="list-style-type: none"> • \$50 wholesale allowance towards any frame. You pay the difference. • Group of select frames at no additional cost 	Reimburses up to \$45 of retail
Contact Lenses <i>Every 12 months in place of eyeglasses</i>		
Medically Necessary	Covered after \$25 materials copay	Reimburses up to \$210
Not Medically Necessary	Covered after \$25 material copay for covered lenses selected from OptumHealth's list. Up to four boxes of covered disposable contact lenses are included when using a network provider. All other contacts available through a \$125 allowance that includes fitting, follow-up & materials. Please note to receive the full \$125 credit, you must receive your exam, fitting evaluation and all contact materials at the same provider at the same time. (At Wal-Mart \$70 of the \$125 allowance is allocated to materials and \$55 to professional fees).	Up to \$125 max that includes fit, follow-up & materials
Refractive Eye Surgery Access to discounted provider locations throughout the United States. To find a participating laser eye surgeon, visit our web site at www.myoptumhealthvision.com	Discount only: The in-network benefit is a discount off the full retail price.	No benefits

Remember if you use in-network providers, you are responsible only for your portion of the cost. If you decide to use a non-network provider, you pay everything and file a claim to receive payment according to the out of network payment schedule.

** Must qualify as medically necessary as described in the enrollment booklet.



Employee, Spouse, and Child Life Insurance and AD&D

Employee Life Insurance With Minnesota Life

If you want life insurance protection or you want to supplement the protection you already have, you may choose group term life coverage under the Flexible Benefits Program. The life insurance amount you choose is paid to your beneficiaries, if you die while this coverage is in effect. Your beneficiaries are the persons you name to receive your life insurance benefits.

Available Coverage Amounts

- one times your pay (maximum coverage is \$300,000)
- two times your pay
- three times your pay
- four times your pay
- five times your pay
- six times your pay
- seven times your pay
- eight times your pay
- nine times your pay

If you are a newly eligible employee, you may elect Employee Life Insurance at one (1) times your Benefit Salary up to \$300,000 or Two (2) through Nine (9) times your Benefit Salary up to and including \$200,000. The coverage maximum is \$500,000. If you are age 65 or older, the value of your life coverage is reduced.

Spouse Life Insurance With Minnesota Life

If you choose employee life insurance for yourself, you may also choose spouse life insurance coverage for your spouse. Spouse life insurance premiums are based on the coverage level and employee age. Premiums for spouse coverage are after-tax. However, if you are age 65 or older, the value of your spouse life coverage is reduced.

Available Coverage Amounts

Spouse Life - \$ 6,000 - \$ 12,000 - \$ 30,000
- \$ 60,000 - \$100,000 - \$150,000
- \$200,000 - \$250,000

Spouse Life coverage cannot exceed 100% of your amount of Employee Life coverage.

You are the beneficiary of spouse life insurance coverage and will receive the insurance benefit in the event of your spouse's death.

If you are a newly eligible employee, you may elect \$300,000 or less of spouse life coverage without medical underwriting.

Child Life Insurance With Minnesota Life

If you choose life insurance for yourself, you may also choose child life insurance coverage for your child(ren). Child life insurance premiums are after-tax.

Available Coverage Amounts

Child Life - \$ 3,000 - \$ 6,000 - \$ 10,000
- \$ 15,000 - \$ 20,000

Your children are eligible for coverage if they are:

- Unmarried, dependent on you for support and under age 19.
- Unmarried and a full-time student under age 26.

If you are a newly eligible employee, you may elect child life coverage without medical underwriting.



Employee, Spouse, and Child Life Insurance and AD&D

Continued

Important Notes about Child Life:

- For the \$3,000, \$6,000, \$10,000, \$15,000 or \$20,000 child coverage levels, the child coverage can begin at live birth. Coverage from live birth to 6 months is the lesser of the elected amount or \$6,000. From 6 months of age to age 19 or 26, the full amount elected applies.
- Child Life coverage cannot exceed 100% of your amount of Employee Life coverage. Physically and/or mentally handicapped children covered under Child Life may continue to be covered beyond the age of 19.
- You are the beneficiary of child life insurance coverage and will receive the insurance benefit in the event of the child's death.

Accidental Death and Dismemberment Insurance *With Minnesota Life*

The Flexible Benefits Program offers accidental death and dismemberment (AD&D) insurance to be paid to you or your beneficiary if your death or injury is the result of a covered accident. In case of permanent and total disability, you are eligible for AD&D benefits if your injury prevents you from working at any job for which you are qualified by education, training, or experience.

Available Coverage Amounts

- one times your pay
- two times your pay
- three times your pay
- four times your pay

- five times your pay
- six times your pay
- seven times your pay

The coverage maximum is \$500,000. If you are age 75 or older, the value of your coverage is reduced.

Important Notes about Employee, Spouse, Child Life and AD&D Insurance

- The life and AD&D insurance amounts you choose will be based on your Benefit Salary as of October 1, 2009. This amount is rounded up to the next higher \$1,000, after you multiply your coverage and the premium has been adjusted for your October 1, 2009 pay and age.
- If your coverage selection requires medical underwriting, you will need to complete the Minnesota Life Evidence of Insurability Form along with any other required information. An approval by Minnesota Life, the insurance carrier, must be made before coverage can be in effect.
- Be sure to designate your beneficiaries by accessing the Minnesota Life LifeBenefit web site on TGC/Flex and clicking on the Beneficiary Management link under Life Insurance. Also, you can change and update your beneficiaries at any time.
- For information regarding conversion and portability of your Employee Life, Spouse Life, and Child Life insurance, contact Minnesota Life Insurance toll-free at 1-800-660-2519.



Short and Long Term Disability

To help provide income protection against the unexpected, the Flexible Benefits Program allows you to choose:

- Short-Term Disability insurance and/or
- Long-Term Disability insurance.

Short-Term Disability *With The Standard*

If you choose short-term disability (STD) coverage, this plan will work with other income benefits to replace 60% of your Benefit Salary (in effect during the Plan Year the disability began) up to \$800 per week. If you receive other benefits, (such as Social Security, workers' compensation, other disability plans and/or programs including the State retirement systems) that total 60% of your Benefit Salary, the short-term disability plan will not pay for this disability.

Your Options

- Seven (7) Day Benefit Waiting Period
- Thirty (30) Day Benefit Waiting Period

How STD Works

In general:

- A late enrollment penalty may apply for late entrants to the STD plan (employees who do not elect STD when first eligible).
- Your STD benefits are calculated on the Benefit Salary that is in effect during the Plan Year your disability began, less other income benefits. For example, if your first day of disability is December 3, 2009, your disability benefit will be calculated from the 2009 Benefit Salary, not your 2010 Benefit Salary.
- Your STD benefits can continue until you recover, return to work, or receive

benefits for a maximum of 150 calendar days or a maximum of 173 calendar days, depending on the coverage level you have chosen. The calendar-day maximums are reduced by any days of paid sick leave, donated leave or Special Injury Leave that you use which exceeds the applicable wait period.

- When changing from the 30-day Benefit Waiting Period to the 7-day Benefit Waiting Period, a Pre-Existing clause is applicable. If you have a condition for which you should have sought medical care or which originated prior to the 7-day Benefit Waiting Period effective date, you will be subject to the rules of the 30-day Benefit Waiting Period until you are on the plan for 12 consecutive months. The Pre-Existing clause does not apply to accidental injuries.

What Is A Late Enrollment Penalty For Late Entrants?

A current employee choosing coverage for the first time or re-enrolling after discontinuing coverage is considered a late entrant. For STD late entrants, who become disabled due to Physical Disease, Pregnancy, or Mental Disorder, during the 12-month period after the date your STD insurance becomes effective, benefits will not begin until after you have been disabled for 60 days until you are on the plan for 12 consecutive months. For STD late entrants whose disabilities begin after this 12 month period, benefits will start after the benefit waiting period (7 or 30 continuous calendar days) is satisfied for STD.



Short and Long Term Disability

Continued

Enrolling For Short-Term Disability Coverage

Your premiums will be based on your coverage level and Benefit Salary. Since you pay for this coverage with after-tax premiums, you won't pay taxes on the benefits you receive.

NOTE: Employees should check with your agency concerning leave usage policies when disabled. Agency policy may impact your eligibility to receive Short-Term Disability benefits.

Long-Term Disability *With The Standard*

Long-Term Disability Protection

The Flexible Benefits Program's Long-Term Disability (LTD) coverage works with other benefits you are eligible to receive, including Social Security, workers' compensation, other disability plans and programs, including the State retirement systems. The plan assures that your combined disability benefits from all these sources will equal 60% of your Benefit Salary up to \$4,000 a month.

How Long LTD Benefits May Be Payable

These benefits will begin after you have been disabled for 180 calendar days and are reduced by any sick leave you use. LTD benefits end when you are no longer disabled or reach age 65, except benefits for disabilities caused by mental disorders, or other limited conditions, which are limited to two years. If you become disabled after reaching age 60, however, your benefits could continue for a limited period after age 65.

Enrolling For Long-Term Disability Coverage

Your cost for long-term disability coverage is based on your age, your FICA Status, Benefit Salary, and whether or not you are eligible for disability coverage through any State of Georgia retirement plan, and/or through Social Security.

LTD premiums are paid with pre-tax dollars. These benefits are considered taxable income and you are responsible for paying taxes to the Internal Revenue Service (IRS).

If you have any questions about eligibility or how the short-term and long-term disability insurance plans work, call 1-888-641-7186.

Long-Term Care With Unum

Long-Term Care refers to a wide range of personal care, health and social services for people of all ages who suffer a chronic disease or long-lasting disability. These services can be provided in a nursing facility, an adult day care center or at home, and can involve some nursing care. The cost for this kind of care is very high. Home care can be as much as \$20,000 per year, and nursing home care can range in cost from \$20,000 to \$60,000 annually. Generally, you pay these expenses out of your own pocket, because medical insurance and Medicare do not cover long-term care.

Your Long-Term Care Options

You can choose from one of three daily benefit levels and the corresponding monthly premium that is right for your needs and budget. The amount of the benefit depends on two factors: where the long-term care is provided - either in a nursing facility, or home/day/assisted living facility - and the daily dollar level of the coverage you have selected. With any of these daily benefit options, benefits are paid on a monthly basis. The monthly benefit is equal to 100% of your elected daily benefit amount for care provided in a state-licensed nursing home facility, and 60% of your elected daily benefit amount for care provided in an assisted living facility or at home. If you wish, you can add on a reduced paid-up option and/or an inflation protection option.

Who Can Be Covered

This plan is offered to you, your spouse, your parents or your parents-in-law. "Parents" are biological (natural), adoptive, or step-parents of eligible employees or

spouses. Your spouse, parents and parents-in-law will have to complete a medical underwriting process and be approved to be accepted for LTC coverage. Your family members' premiums will be billed directly by the insurance company. Your payroll deduction will be for your individual coverage only.

When Benefits Are Paid

Benefits begin after a 90-day waiting period in which you or a covered family member has an eligible physical or cognitive disability. You qualify for benefits if the disability creates a need for you to receive continual help from another person to carry out any three of the following six activities of daily living. Benefits from long-term care insurance are not taxed when you receive them.

About Your Premiums and Enrolling

You pay for your LTC coverage through the convenience of payroll deduction with after-tax dollars. Premium costs are based on your age as of the Benefit Calculation Date (October 1). Your family members' premiums are based on their age as of the date they apply for coverage. Their premiums will be sent directly to Unum, not deducted from payroll.

If you are a current employee and selecting LTC insurance for the first time, or are currently enrolled and want to increase your benefit level or add options, or are re-enrolling after discontinuing coverage, medical underwriting may be required. As a newly eligible employee, you may select LTC with no medical underwriting required. For more information about long-term care coverage, call Unum at 1-888-SOG-FLEX (1-888-764-3539).



Specified Illness Plan With Continental American Insurance Company

With the group specified illness plan, our goal is to help you and your family cope with and recover from the financial stress of surviving a critical illness or condition.

Employee coverage levels:

- \$ 5,000 • \$10,000 • \$20,000
- \$30,000 • \$40,000 • \$50,000
- Lump-sum benefits paid directly to the insured following the diagnosis of each covered specified illness after you are hospital confined for the specified illness and charged for room and board. (See the chart below for information on covered specified illnesses.)
- Rates cannot be individually increased due to change in age, health or individual claim.
- No medical underwriting required for up to \$20,000 in coverage, and simplified medical underwriting process with only a few health questions.
- The plan is portable* - take your coverage with you if you leave your job.
- Available to employees age 18-69.
- Benefits for participants reduced 50% at age 70.

Spouse coverage levels:

- \$5,000 benefit • \$10,000 benefit
- No medical underwriting required
- Employee must have coverage for the spouse to have coverage
- Rates are based on employee age

Child coverage:

- Children covered at no additional cost
- All children are covered at 25% of employee benefit amount
- Children ages 0 – 24, if a dependent

- Child coverage automatically included in existing employee coverage

Covered Cricital Illnesses*	
Illnesses Covered under the Plan	Percentage of Face Amount
Heart Attack	100%
Stroke	100%
Major Organ Transplant	100%
Renal Failure (End Stage)	100%
Internal Cancer	100%
Coma (NEW!)	100%
Severe Burns (NEW!)	100%
Paralysis (NEW!) Loss of Sight, Hearing , or	100%
Speech (NEW!)	100%
Carcinoma in situ	25%
Coronary artery	25%

First Occurrence Benefit

After receipt of written proof of loss, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Additional Occurrence Benefit

If an insured collects full benefits for a Critical Illness under the plan and later has one of the remaining covered illnesses, then we will pay the full benefit amount for any additional illness. Occurrences must be separated by at least 6 months.

Re-Occurrence Benefit

If an insured receives full benefit for a covered condition and is later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis

must be separated by at least 12 months or 12 months treatment free for Internal Cancer.

Health Screening Benefits

An insured may receive a maximum of \$100 for any one covered screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the policy remains in force. This benefit is payable for the covered employee. The covered health screening tests include:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)

- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermography

*Certain stipulations apply to portability.

**A partial benefit (25%) is payable for carcinoma in situ and coronary artery bypass surgery. Payment of the partial benefit for carcinoma in situ will reduce the benefit for internal cancer. Payment of the partial benefit for coronary artery bypass surgery will reduce the benefit for a heart attack.



Legal Insurance Plan *With Signature LegalCare*

Everyday occurrences often require legal assistance, whether it's selling a home, establishing a will, defending a traffic ticket, or addressing a variety of other legal matters. Attorney fees can be costly, ranging from hundreds to thousands of dollars.

With legal insurance, you have the freedom and flexibility to deal with debt collection defense, adoptions, divorce, wills, estate administration, and more. Experienced Participating Attorneys can answer many of your questions over the phone. In many instances, the plan will cover the entire cost of your attorney fees when you use a Participating Attorney.

Legal Insurance Benefits:

➤ **Telephone Advice**

This benefit provides the opportunity for a Covered Person to discuss with an Attorney personal legal problems that are not specifically excluded under the Plan. This service is available through an independent law firm referred to as the Preventive LegalCare Office (PLCO). The Covered Person will not be billed for this service, there is no limit to how often the service is used, and there are no claim forms to be completed.

➤ **Reduced Fee Benefit**

For legal fees that are not otherwise covered by the Plan, a Participating Attorney who elects to provide this benefit will charge his/her fees at a rate at least twenty five percent (25%) less than his/her usual and customary rate ("UCR"). Plan exclusions apply.

➤ **Maximum Contingent Fee Benefit**

For any matter that is not otherwise covered by the Plan and for which a Participating Attorney who elects to provide this benefit normally charges a contingent fee (common for personal injury claims and other matters for which a Covered Person as a plaintiff anticipates being paid or awarded a large sum of money), the Participating Attorney will charge no more than the following maximum percentages:

- twenty five percent (25%) for all activities up to and including initial trial or settlement (including consultation and review)
- thirty percent (30%) for all activities relating to the appeal of an initial judgment, including appellate hearing and settlement

These limits apply to the attorney's fees, only, not to other costs not normally included as part of the Participating Attorney's professional fees. Plan exclusions apply.

➤ **Personal Law Center**

The Personal Law Center is an online resource that is accessible through the Signature LegalCare Web site. It provides Covered Persons with unrestricted online access to a library of plain-English and easy-to-use legal and financial information, self-help forms, and interactive documents and tools.

➤ **In-Office Legal Services**

The Signature LegalCare® plan makes in-office attorney visits easy! A Participating Attorney will provide you with advice on most covered legal matters with attorney fees completely



covered. If there isn't a Participating Attorney in your area, the plan will cover the services of a Non-Participating Attorney on the same basis as for services provided by a Participating Attorney.

You may also choose to see a Non-Participating Attorney of your choice. For services provided by a Non-Participating Attorney, the plan will reimburse you at a rate of \$17.50 per quarter hour up to a maximum benefit amount. You are responsible for the balance of the attorney's fees. When covered services have been completed, file a claim form, including your attorney's billing statement, with Signature LegalCare. You'll receive direct reimbursement for the attorney's services, up to the maximum allowed by the Plan.

Your Options

Select Option

The Select option provides benefits for the following services:

- Document Preparation
- Attorney Office Work – Four (4) hours each plan year
- Real Estate Matters
- Traffic Charges
- Wills and Trusts

Select Plus Option

The Select Plus option offers the same services as the Select option with these additional services:

- Adoptions
- Attorney Office Work – Additional four (4) hours each plan year
- Child Custody/Child Support
- Consumer Protection
- Debt Collection Defense
- Defendant Civil Action Benefit
- Document Review
- Estate Administration and Estate Closing
- Eviction Defense
- Guardianship/Conservatorship
- Immigration/Naturalization
- Internal Revenue Service Audit
- Juvenile Court Proceeding
- Matrimonial Matters
- Name Change

For additional information on Signature LegalCare® benefits or if you have questions concerning how the legal services insurance plan works, you may call Signature LegalCare® at 1-800-848-2012 or visit their web site at www.SignatureLegalCare.com. Scroll down to State of Georgia enter the appropriate 5-digit password for the Select Plan (43315) or Select Plus Plan (43215).

Spending Accounts *With SHPS*

Spending accounts let you pay for certain eligible health and/or dependent care expenses using pre-tax dollars. They offer tax savings by letting you pay for out-of-pocket expenses with pre-tax money. This can mean savings of approximately 20%-40%, depending on your individual tax situation!

For the 2010 Plan Year, the spending accounts being offered are:

	Health Care Spending Account	Dependent (Child) Care Spending Account
Annual Maximum	\$5,040	\$4,992
Annual Minimum	\$ 120	\$ 120

The IRS rules and the rules of the Employee Benefit Plan Council designate eligible expenses and the Employee Benefit Plan Council has the responsibility to interpret these rules and make all decisions as to an expense's eligibility.

Health Care Spending Account (HCSA)

The Health Care Spending Account (HCSA) helps you save tax dollars on the health-related treatment you and your family receive.

Some of the eligible expenses include:

- Deductibles and co-payments not paid by any health or dental insurance in which you or your family members participate;
- Costs for procedures not covered or not covered fully by a health, dental or vision plan;
- Specialized equipment for disabled persons;
- Preventative care screenings;
- Contact lens and glasses;

- Laser eye surgery;
- Prescription and over-the-counter medicine;
- Mental health services;
- Physical therapy; and
- Certain other IRS approved expenses.

A few examples of expenses that are not eligible include:

- Cosmetic procedures/drugs
- Electrolysis
- Hair transplants
- Herbal supplements
- Insurance premiums
- Nicotine patches and gum
- Nutritional supplements
- Teeth whitening/bonding
- Vitamins

For further information on potentially eligible expenses, see IRS Publication 502, available at your personnel/payroll office, your local public library or IRS office, or online at www.irs.gov/prod/forms_pubs/pubs/pubs.html.

➤ The Debit Card

When you enroll in a Health Care Spending Account, you'll receive a VISA® Spending Account Card for purchases of eligible healthcare expenses. You will automatically receive the Card, along with information about the card and how it can be used. You may request up to 4 additional cards with your spouse or dependent's name on it, for a fee of \$5.00 per card. If your card is lost or stolen, you may request another card for a fee of \$15.00. For additional cards, call SHPS at 1-800-893-0763.



➤ **Keeping Receipts**

Remember, you must keep your receipts since some transactions may require validation by SHPS. Depending on the merchant, you may or may not need to submit receipts for over-the-counter purchases made with the card.

➤ **2½ Month Grace Period**

Employees have an additional 2½ months to spend the money in their Health Care Spending Account. This means qualified expenses may be reimbursed for services provided through March 15, 2010. Employees will have until April 30, 2010 to send their claims to SHPS for reimbursement. Remember, if a claim is mailed, the envelope must be postmarked by April 30th. The fastest way to get claims to SHPS is to fax them at 1-866-643-2219.

To best take advantage of this grace period, plan only for expenses you expect to have for the 12 month period. If you do not use all of the money you contributed, you can then use it in the grace period.

Important note: The IRS does not allow participation in Health Care Spending Accounts and Health Savings Accounts.

Dependent (Child) Care Spending Account (DCSA)

The Dependent (Child) Care Spending Account provides you with the opportunity to use tax-free dollars to pay for the care of your children under age 13 or other IRS

eligible dependents while you and your spouse work or go to school full time.

Childcare services may include your cost to send a child to preschool, after school, or nursery school. Also, expenses for dependents of any age who are unable to care for themselves because of a physical or mental handicap are eligible. A person qualifying for this type of care must spend at least eight hours a day in your home. Elderly dependent care may include your cost to send a dependent parent to an elderly daycare facility or to have someone to care for them in your home.

If you are married, both you and your spouse must be working or a full-time student during the time the care is received. Your income tax return (long and short forms) will require you to include your dependent care provider's name and tax number or Social Security number.

Dependent (Child) Care Spending Account Exclusions List

These are a few examples of dependent care expenses that are not eligible for reimbursement:

- Activity and book fees
- Cleaning and cooking services not provided by the care provider
- Field trips
- Food, clothing, and entertainment
- Kindergarten
- Overnight camps
- Sports lessons
- Transportation to and from the child care provider
- Tuition to private school



Spending Accounts

Continued

NOTE: You should carefully review your options and consult a qualified tax advisor for assistance in determining using the Dependent Care Tax Credit or using the Dependent Care Spending Account.

Dependent (Child) Care Spending Account Limits

You may not be able to deposit the full \$4,992 if any of the following situations apply to you:

- If your spouse works for the State or another employer who offers a similar plan, the total of your family's contributions to a dependent (child) care spending account cannot exceed \$4,992.
- If either you or your spouse earns less than \$5,000 a year, you can deposit as much as the smaller of your two incomes.
- If your spouse is either a full-time student or incapable of self-care, you may deposit up to \$3,000 for one dependent, or \$4,992 for two or more dependents.
- If you are married but file a separate federal income tax return, you may deposit a maximum of \$2,500 to your dependent (child) care spending account.
- If you are hired after January 1 or have a qualified change in status during the plan year (see Terms and Conditions in the back of this booklet), you may contribute up to \$416 per month for the remainder of the plan year.

Important Information About Spending Accounts

- ❖ Reductions for spending accounts are made every pay period. But remember to enter the monthly amount you want to contribute on your web Option Statement.

- ❖ Your spending account enrollment is binding for the plan year. You may be able to make limited changes if you have a qualified status change.
- ❖ You cannot carry over expenses that you have incurred in one plan year into the next plan year for reimbursement.
- ❖ Claims should only be submitted after services have been provided.
- ❖ You may submit claims at any time for any amount, but payment will not be made until your claims total \$25 or more. Reimbursement may be by check or by direct deposit to your bank account.
- ❖ You receive a bi-monthly statement showing how much you have in each account.
- ❖ You cannot transfer money from one account to another.
- ❖ Reimbursements are issued on a daily basis.
- ❖ Spending account claims for the 2009 Plan Year (January 1 - December 31, 2009) must be faxed or mailed with correct documentation and postmarked on or before **April 30, 2010**.
- ❖ Spending account claims for the 2010 Plan Year (January 1 - December 31, 2010) must be faxed or mailed with correct documentation and postmarked by **April 30, 2011**.
- ❖ Under IRS rules, any money left in your accounts and not claimed for the previous plan year's expenses by the claim filing deadline is forfeited. It is retained by the plan and used for administrative expenses.

Contact the Flexible Benefits Program at 404-656-2730 or 1-888-968-0490 for more information.



Offered by
the Georgia Higher Education Savings Plan

Start your child on the path to a brighter future.

There are a number of paths to choose from to pay for a child's education. Choose the right one, and virtually any college dream can be within reach. And college can lead to a brighter future. Even if your child receives a HOPE Scholarship or other forms of financial aid, saving for college now is a key step to avoiding loans and providing flexibility down the road.

Now, thanks to a program offered by the State of Georgia — the Path2College 529 Plan, formerly referred to as the Georgia Higher Education Savings Plan (GHESP) — you have a smart and flexible way to help save for future higher education expenses.

With a Path2College 529 Plan account, you don't pay Georgia or federal taxes on earnings as your account grows. Then, when it's time to pay for college, the money you withdraw for qualified higher education expenses is also Georgia and federal tax-free. In addition, Georgia offers a state income tax deduction for up to \$2,000 in contributions for each beneficiary.

With the Path2College 529 Plan, you can choose from seven investment options designed to meet your savings goals. There are no start-up or application fees, no maintenance fees, and no sales charges or broker commissions. You pay only a low annual management fee of less than one percent.



Start your child on the path to a brighter future.

It's easy to enroll.

Don't worry about a big up-front financial commitment. You can open an account for as little as \$25 per contribution. And the Path2College 529 Plan offers an Automatic Contribution Plan that drafts your checking or savings account, or you can sign-up for the payroll deduction program and contribute as little as \$15 per pay period. Once you start, it's easy to stay on track!

You can obtain enrollment, ACP, and payroll deduction information by contacting the state office of the Path2College 529 Plan at (404) 463-0000 or outside metro-Atlanta at (866) 529-9529 or by email at GA529@otfs.ga.gov. You can also obtain the necessary payroll forms by visiting www.otfs.ga.gov. Click on GHESP Forms and Information and review the Employee Payroll Checklist for New Accounts (if you do not currently have an account), or the Employee Payroll Checklist for Existing Accounts (if you already have an account). And visit www.path2college.com for more information.

Please note: Payroll contributions are made using after-tax dollars; therefore, you are not subject to the limits and restrictions for flexible benefits during the Annual Enrollment period. Your payroll deduction can be started, stopped, increased or decreased at anytime during the year by contacting us at the numbers above.



EMPLOYEE CHECKLIST

Employee Checklist

- ✓ Check with personnel/payroll office for deadlines.
- ✓ Review the enrollment booklet, providing you with valuable information for each option descriptions of required supplemental for medical underwriting requirements, and Terms & Conditions.
- ✓ Check on the website (www.team.georgia.gov/flex) to confirm if additional forms are required, such as medical underwriting forms.
- ✓ Review your Confirmation Statement thoroughly and immediately report discrepancies to personnel/payroll office. Follow-up to assure corrections were made.
- ✓ Compare your pay stub(s) against options selected. Contact your personnel/payroll office with discrepancies.
- ✓ Report any incorrect information to your personnel/ payroll office.

Other Important Information

For questions about claims or benefits for the State Health Benefit Plan, see page Benefit Phone Directory for phone numbers.

For general questions about the Flexible Benefits Program, call 404-656-2730 if it's a local Atlanta call, or toll-free at 1-888-968-0490 outside the local area.

The Flexible Benefits Program attempts to be as consistent as possible with State Health Benefit Plan rules and regulations. This is not always possible due to the variations in benefit offerings.

This booklet summarizes the benefits you can choose through the State of Georgia Flexible Benefits Program. A more detailed explanation of benefit provisions is provided in each benefit Summary Plan Description. Every attempt has been made to ensure that the information in this booklet is accurate.

The State of Georgia Flexible Benefits Program is governed by legal documentation and insurance contracts. However, in the event there are any conflicts between this booklet and the official plan descriptions and contracts, the terms of the official plan descriptions and contracts will prevail.

The Flexible Benefits Program is governed by the current tax law and is subject to and operated in accordance with the regulations of the Internal Revenue Service (IRS). If changes in the Program are necessary to comply with the law or IRS regulations, you will be notified.



PRIVACY AND SECURITY NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities, including state agencies that deal with Protected Health Information (PHI), provide you with this notice. This notice pertains to those programs specifically administered by the State Personnel Administration (SPA) in which SPA may maintain various types of PHI about you. SPA understands that information about you and your family is very personal. As such, SPA is committed to protecting and securing your information.

This notice tells you how SPA uses and discloses information about you and discusses your rights in keeping this information private and secure. Please review this notice carefully.

Overview

What is HIPAA?

HIPAA, the Health Insurance Portability and Accountability Act of 1996, is a federal law regarding the confidentiality and security of Protected Health Information (PHI). It imposes restrictions on how your health information can be used and shared and confirms rights for individuals concerning their own health information.

What is PHI?

PHI, Protected Health Information, is individually identifiable health information that is maintained or transmitted by a covered entity. It is information related to a person's health, provision of care, or payment. Examples of items containing PHI include: a bill for health services, an explanation of benefits statement, receipts for reimbursement from a health flexible spending account or any list

showing the amount of benefits paid with a breakdown by social security number. This also includes your employer (state agency, school system, authority, etc.) transmitting information about you to SPA. This information may include your name, address, birth date, social security number, employee identification number and certain health information

How SPA Uses and Discloses Protected Health Information

When services are contracted, SPA may disclose some or all of your information to the company to perform the job SPA has contracted with them to do. SPA requires the company to safeguard your information in accordance with federal and state law.

Privacy and Security Law Requirements

SPA is required by law to:

- Maintain the privacy of your information.
- Protect electronic PHI by implementing reasonable and appropriate physical administrative and technical safeguards.
- Provide this notice of SPA's legal duties and privacy and security practices regarding the information that SPA has about you.
- Abide by the terms of this notice.
- Refrain from using or disclosing any information about you without your written permission, except for the reasons given in this notice. You may revoke your permission at any time, in writing. That revocation will not apply to information that SPA disclosed prior to receiving your written request. If you are unable to give your permission due to an emergency, SPA may release information, if it is in your best interest. SPA must notify you as soon as possible after releasing the information.



PRIVACY AND SECURITY NOTICE

Continued

Your Health Information Rights

You have the following rights regarding the health information maintained by SPA about you:

- You have the right to see and obtain a copy of your health information. This right would not extend to information needed for a legal action relating to SPA.
- You have the right to ask SPA to change health information that is incorrect or incomplete. SPA may deny your request under certain circumstances or request additional documentation.
- You have the right to request a list of the disclosures that SPA has made of your health information beginning in April 2003.
- You have the right to request a restriction on certain uses or disclosures of your health information. SPA is not required to agree with your request.
- You have the right to request that SPA communicate with you about your health in a way or at a location that will help you keep your information confidential.
- You may request another copy of this notice from SPA, or you may obtain a copy from the SPA web site, www.spa.ga.gov (under "Privacy").

For More Information and To Report a Problem

If you have questions and would like additional information about Protected Health Information (PHI) you may contact the SPA Privacy Officer at 404-656-2730 (Atlanta calling area) or 1-888-968-0490 (outside of Atlanta calling area). You may also visit SPA web site, www.spa.ga.gov.

SPA does not discriminate on the basis of disability in the admission or access to, or treatment of employment in its programs or activities. If you have a disability and need additional accommodations to participate in any SPA programs, please contact the SPA at the numbers listed. For TDD relay service only: 1-800-255-0056 (text-telephone) or 1-800-255-0135 (voice).

If you believe your privacy or security rights have been violated:

- You may file a complaint by calling the SPA Privacy Unit at 404-656-2730 (Atlanta calling area) or 1-888-968-0490 (outside of Atlanta calling area), or by writing to:
State Personnel Administration
Attn: Privacy Officer
2 MLK Jr. Drive, SE
Suite 502, West Tower
Atlanta, GA 30334
- You can file a complaint with the Secretary of Health and Human Services by writing to: Secretary of Health and Human Services, 200 Independence Ave. SW, Washington, DC 20201. For additional information, call 1-877-696-6775.
- You may file a grievance with the United States Office for Civil Rights by calling 1-866-OCR-PRIV (1-866-627-7748) or 1-886-788-4989 TTY.

There will be no retaliation for filing a complaint or grievance.

If SPA changes its privacy or security practices significantly, SPA will post the new notice on its web site at www.spa.ga.gov (Under "Privacy"). This notice, effective April 14, 2003, was amended April 20, 2005.



Benefit Phone Directory

Flexible Benefits Program

404-656-2730
1-888-968-0490

Employee, Spouse, Child Life Insurance and Accidental Death and Dismemberment
Life conversion and 1-800-660-2519
Portability information

Dental Insurance
CIGNA - www.cigna.com 1-800-642-5810
United Concordia-Regular & PPO 1-866-215-2356
www.ucci.com/tuctcc/clients.jsp?id=18

Vision Coverage 1-800-638-3120
www.myoptumhealthvision.com

Disability Insurance 1-888-641-7186

Long-Term Care Insurance 1-888-SOG-FLEX or 1-888-764-3539

Legal Insurance 1-800-848-2012
Hearing Impaired 1-800-535-2348
www.signaturelegalcare.com

Spending Accounts 1-800-893-0763
Hearing Impaired 1-800-952-0450
www.shps.net

Specified Illness Insurance 1-800-433-3036
Portability Information 1-800-433-3036
www.gms-specifiedillness.com

State Health Benefit Plans

SHBP Eligibility 1-800-610-1863 404-656-6322

United Healthcare of Georgia
Health Reimbursement Arrangement (HRA) 1-800-396-6515
High Deductible Health Plan (HDHP) 1-877-246-4189
Open Access Plan (OAP) 1-877-246-4189
Health Maintenance Organization (HMO) 1-877-246-4189
Retirees 1-877-755-5343

CIGNA Healthcare
Active Employees 1-800-633-8519
Retirees 1-800-942-6724

TERMS & CONDITIONS

The Flexible Benefits Program is offered by the Employee Benefit Plan Council, the Board of Community Health and participating departments and authorities. The Flexible Benefits Program is governed by the Internal Revenue Code, section 125, and rules issued by the Employee Benefit Plan Council and the Board of Community Health. The Flexible Benefits Program provides you with a method to have your employer purchase benefits with money that would have been paid to you. You do not receive the premium amounts and contributions for the pre-tax options you select as taxable income (and therefore do not pay taxes on that amount); you do receive the benefits as an employer paid benefit. The Option Statement, either paper or electronic, is a binding salary agreement. Failure to comply with all contractual and administrative requirements will result in any excess salary reductions being retained by the Plan. The following statements apply to the benefit options listed on the Option Statement and on the Annual Enrollment web site.

- 1) Your participation in the Flexible Benefits Program is voluntary. You are not required to choose any of the options. If you do not wish to participate in these benefits, mark 'no coverage' in each benefit category, sign and date the paper Option Statement, and return it to your personnel or payroll office. If you choose your benefits through web enrollment, click 'no coverage' in each benefit category and complete the confirmation process.
- 2) Some coverage levels available to you and the premium amount for each coverage level may be calculated using your retirement salary, your age, your eligibility for disability retirement benefits, and FICA status on your date of hire or the Benefit Calculation Date, which ever is deemed appropriate by the Plan Administrator. Any adjustments to the Benefit Salary, with the exception of errors (as determined by the Plan Administrator) shall be reflected on the following Benefit Calculation Date, to be effective for the following Plan Year. Promotions, demotions, adjustments due to certifications are not deemed to be errors. Any errors in these items should be reported to your personnel or payroll office immediately.
- 3) The calculation of tax savings does not take into consideration any other income earned by employee or family members, income reduction program such as Deferred Compensation or Tax Sheltered Annuities, or any changes you may make in coverages for the upcoming year.
- 4) By selecting coverages and indicating contributions to Spending Accounts, you are agreeing that your agency may reduce your taxable income by the amount necessary to purchase those coverages and make those contributions. Except in certain circumstances, the amount of income reduction may not be changed until the next enrollment period.
- 5) For dependent and/or spousal coverage, it is your responsibility to notify the Flexible Benefits Program if the person ceases to be eligible to participate in the Plan. There will be no refund of premiums paid into the Plan, when a timely change is not made.
- 6) After this enrollment period you may become a participant or make changes in some coverages only under limited conditions in accordance with the rules of the IRS code, the Employee Benefit Plan Council, and the Board of Community Health. The Employee Benefit Plan Council and the Board of Community Health have the responsibility to interpret these rules and make the final decision as to whether you may enroll or change any coverage outside of the enrollment period. Your request for enrollment or a change outside of the enrollment period will only be considered if you submit the proper documentation within the timeframe allotted. To submit a request for enrollment or change to coverage under the State Health Benefit Plan, you must complete and submit a Membership or Discontinuation Form to your employer's Benefits Coordinator within 31 days. Your request for enrollment or a change in any other coverage under the Flexible Benefits Program must be submitted in writing to your employer's Benefits Coordinator within 30 days. Submission of a request for enrollment or a change, or the occurrence of one of the following events, does not guarantee that you will be able to enroll or change coverage outside the enrollment period. Please see your Benefits Coordinator if you have questions about when you may enroll or make changes outside the enrollment period. A list of events that might permit you to enroll or change one or more coverages under the Flexible Benefits Program:
 - a) You gain or lose a spouse; or
 - b) You gain (no time limit if due to judgment, decree or order) or lose an eligible dependent; or
 - c) Your spouse or dependent becomes eligible for or loses coverage under another employer's plan, COBRA or a governmental plan; or
 - d) An event causes your dependent to gain or lose eligibility for coverage under your employer's plan; or
 - e) Your change of residence causes you or your spouse or dependents to gain or lose eligibility for coverage under your plan or another employer's plan; or
 - f) The cost of your dependent care increases or decreases significantly and your dependent provider is not related to you, your spouse, or your dependent; or
 - g) Your spouse's employer increases, decreases or ceases coverage, or conducts open enrollment; or
 - h) You, your spouse or your dependent gain or lose eligibility for Medicare or Medicaid.
- 7) This salary agreement will be terminated if you change the agreement during the next enrollment period. If you do not change the agreement, your benefit choices will rollover in the next Plan year or default to a specified coverage.
- 8) If you are eligible to participate in the Plan, you terminate and are rehired during the same Plan Year, you must maintain the same options.
- 9) Options and coverage levels under the State Health Benefit Plan are set forth in the State Health Benefit Plan Document. Options and coverage under the Flexible Spending Accounts are set forth in the Flexible Benefit Plan Document. For all other benefits under the Flexible Benefits Program, the options and coverage levels offered conform to policies provided by the insurance company making the offer. By selecting an option and coverage level you agree to abide by the terms and conditions of that policy.
- 10) Contributions to Spending Accounts are voluntary. You should not participate in Spending Accounts until you thoroughly read the sections of the Enrollment Booklet related to Spending Accounts. By choosing to contribute money to one or more Spending Accounts you are agreeing to abide by the Rules of the Employee Benefit Plan Council related to Spending Accounts. In particular, you are agreeing to the following provisions:
 - a) Money contributed for one type of Spending Account cannot be used to pay claims payable from another type of Spending Account.
 - b) In general, the amount contributed for a Dependent Care Account cannot be greater than the earned salary of you or your spouse, whichever is less.
 - c) If you are married filing separately, the amount contributed for a Dependent Care Account cannot be greater than \$2,500.
 - d) The validity of a claim against a Spending Account is determined in accordance with the Plan, Internal Revenue Code, and IRS regulations as interpreted by the Administrator subject to the appeal provisions of the Plan.
 - e) Any money not reimbursable to you will be forfeited to the Flexible Benefits Program. Forfeited money will not be returned or paid to the employee but will be used to reduce the costs associated with providing this benefit.
 - f) For the Spending Accounts, eligible expenses will be reimbursed in accordance with the Rules of the Employee Benefit Plan Council and the IRS code.
 - g) For the Dependent Care Spending Account, you will not be reimbursed for more than the Plan has received from your department on your behalf.
 - h) If you decide to activate and use the Spending Account debit card, you agree to abide by all requirements as indicated in the cardholder agreement received with the card.
- 11) By selecting the Specified Illness Benefit, you are agreeing to the following:
 - a) I am asserting that to the best of my knowledge and belief, the answers to the questions on the application are true and complete. They are offered to American General Assurance Company as the basis for any insurance issued. It is understood and agreed that coverage will not become effective unless I am actively at work on the date of enrollment and the effective date of coverage.
 - b) I understand and agree that no benefits are payable for loss starting or occurring within 12 months of the effective date of coverage which is caused by, contributed to by, due to or resulting from a Pre-existing condition, unless I have gone 12 months without medical care, treatment or supplies for the Pre-existing condition.
 - c) I realize that any false statement or misrepresentation may result in loss of coverage under the certificate. I understand that no insurance will be in effect until approved by American General Assurance Company and the necessary premium is paid. Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
 - d) I authorize my employer to deduct the appropriate amount from my earnings and to deduct and pay American General Assurance Company the premium required thereafter each month for my insurance.
- 12) Other terms and conditions:
 - a) If you choose not to participate or choose not to continue coverages, your ability to enroll at a later date will be subject to contractual provisions, which may include medical proof of insurability or limited coverages.
 - b) If you failed to enroll in options requiring medical underwriting when first eligible and you choose new or increased levels of coverage, you must complete the medical underwriting process and be approved.
 - c) If you choose coverage under the Life Insurance options and the Accidental Death and Dismemberment options, the same Beneficiary Election Form will be used. If a beneficiary is not named, the beneficiary will follow the order stated in the policy.
 - d) If you select more than \$50,000 under the Life Insurance option, you may choose to pay the premium with after-tax dollars to avoid imputed income; this will eliminate any tax savings on the life insurance premium.
- 13) In the event of an administrative error with respect to the Flexible Benefits Program, decisions will be made in accordance with the Internal Revenue Code, the Rules of the State Health Benefit Plan, and the Rules of the Employee Benefit Plan Council for the Flexible Benefits Program.